Blood Systems

Submitting Facility: ______________________________

Contact Person:

Phone Number:

Bone Marrow & Progenitor Cell Processing Prescription

Collection Date(s):	Collection Date(s):
Recipient Name: Diagnosis:	Donor Name:
Recipient ID No.: Recipient DOB:	Donor ID No.: Donor DOB:
Recipient Registry No.:	Donor Registry No.:
Recipient SSN: Recipient ABO/Rh:	Donor ABO/Rh:
Recipient Weight: kg	
☐ Known Heparin Allergy or HIT	☐ Known Heparin Allergy or HIT

☐ Autologous ☐ Allogeneic ☐ Donor Leukocytes ☐ Stimulated

☐ PBPC ☐ Bone Marrow ☐ Cord Blood ☐ Unstimulated

Allogeneic

☐ No processing (count and give)

☐ Plasma Reduction (ABO minor incompatibility)

☐ Red Cell Depletion (ABO major incompatibility)

☐ Send out

☐ Cryopreserve aliquots as follows:

Equal aliquots OR

_______ $x10^6$ CD34+/kg ___________ # bags

_______ x10 CD3+/kg ___________ # bags

_______ x10 CD3+/kg ___________ # bags

_______ x10 CD3+/kg ___________ # bags

_______ x10 CD3+/kg ___________ # bags

_______ x10 CD3+/kg ___________ # bags

☐ Infuse fresh dose: _________ x 10 CD _______ kg

☐ Freeze CD3 aliquots per SOP: ______________________

☐ Other: ______________________________________

Autologous

☐ No treatment; dose required: ___________ $x10^6$ CD34/kg

☐ Buffy Coat

☐ Tandem (PBPC cryopreserved in equal # bags)

☐ Cryopreserve aliquots as follows:

________ $x10^6$ CD34+/kg ___________ # bags

________ $x10^6$ CD34+/kg ___________ # bags

________ $x10^6$ CD34+/kg ___________ # bags

________ $x10^6$ CD34+/kg ___________ # bags

NOTE: Attach Viral Marker Testing < 30 days from anticipated collection date and Statement of Donor Eligibility for all Allogeneic donors.
Request aliquots in desired order of cryopreservation. Provide instructions for any additional cells that do not meet the aliquot requirements.

Additional Instructions: ____

Physician's Signature: ______________________________ Date: ___________

Physician's Name (Print): ______________________________ Phone: ______________

Blood Systems Laboratories
Cellular Therapy Laboratory
2424 W. Erie Dr./Tempe, AZ 85282
Phone 602-343-7103 Fax 602-343-7157

CTL Requisition Form

Date Of Request ____________ Draw Date ____________ UBS Center ____________

Report To ☐ Physician ☐ Laboratory ☐ UBS Center ☐ All Contact Person ____________

Referring Physician ____________
Facility Name ____________
Address ____________
____
Phone ____________ Fax # ____________
Laboratory ____________
Address ____________
____
Phone ____________ Fax # ____________

Bill To ☐ Physician ☐ Laboratory ☐ UBS Center ☐ Other
(If “Other” above, fill out “Bill To” information below.)
Bill To (If not physician, laboratory or center)
Name ____________
Address ____________
____
Phone # ____________ Fax # ____________

Samples Collected EDTA Qty _____ Other (____________) Qty _____

Item # VD	Quantity	Test Description	Item # VD	Quantity	Test Description
L01031	______	☐ CFU – Colony Forming Assay	L02051	______	☐ CD34/Viability
L01046	______	☐ Complete Blood Count			WBC ______ Vol. ______ Pt. Wt. ______
L03042	______	☐ Manual Differential			
L01035	______	☐ Sterility	L01030	______	☐ CD3
L05045	______	☐ Trypan Blue Viability			

CTL Case #:

Patient Information (Recipient)
Last Name ____________ First Name ____________
Med. Record or SS # ____________ NMDP recipient ID ____________
Birthdate ____________ Sex: ☐ F ☐ M

Donor Information
Last Name ____________ First Name ____________
Med. Record or SS # ____________ NMDP Donor ID ____________
Birthdate ____________ Sex: ☐ F ☐ M Relationship ____________

FOR LABORATORY USE ONLY Report sent: (F = Fax, V = Verbal, W = Written, E = Email)

☐ F ☐ V ☐ W ☐ E To ____________ Date ____________ Time ____________ Tech ____________
☐ F ☐ V ☐ W ☐ E To ____________ Date ____________ Time ____________ Tech ____________
☐ F ☐ V ☐ W ☐ E To ____________ Date ____________ Time ____________ Tech ____________

Comments